TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Shannon Medical Center

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-17-3629-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note we show HCPC's 27687 & 27691 have a status indicator of "T", therefore should not be bundled into the J1 code billed on HCPC 28300."

Amount in Dispute: $4,526.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Liberty Mutual believes that Shannon Medical Center has been appropriately reimbursed for services rendered to (injured employee) for the 08/12/2016 to 08/13/2016 date(s) of service for this Texas Outpatient hospital service."

Response Submitted By: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12 – 13, 2016	28300, 27687, 27691	$4,526.01	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - X936 – CPT or HCPC is required to determine if services are payable
    - 193 – CPT or HCPC is required to determine if services are payable
    - W3 – CPT or HCPC is required to determine if services
    - U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
    - MJIN – Recommended reimbursement is based on CMS hospital outpatient status indicator J1: Comprehensive APC non-complexity adjustment
    - MOPS – Services reduced to the outpatient prospective payment system
    - MCMP – The final recommended reimbursement for CMS hospital outpatient APC composite is reflected on this line
    - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

Issues

1. What is the applicable rule that pertains to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $4,526.01 for outpatient hospital services with date of service August 12 – 13, 2016. The carrier reduced the payment amount as MJIN – "Recommended reimbursement is based on CMS hospital outpatient status indicator J1: Comprehensive APC non-complexity adjustment."

   The requestor states in pertinent part, "Based on their payment of $9,397.68 [sic]for the APC a supplemental payment is still due of $4,526.01 the APC alone, at this time."

   The Respondent states in pertinent part, "Liberty Mutual believes that Shannon Medical Center has been appropriately reimbursed for services rendered..."

   Therefore, the service in dispute will be reviewed per applicable Rules and Fee Guidelines discussed below.

   The relevant portions of 28 Texas Administrative Code 134.403 are:

   (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise

   (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent

Review of the submitted medical claim finds the submitted procedure code 28300 – "Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation."

Review of the Addendum B – "Final OPPS payment by HCPCS Code" found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html, for this date of service shows this code to have a "J1" status indicator which is defined as;

J1 – "Hospital Part B services paid through a comprehensive APC. Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim…"

The Medicare Payment Policy regarding Comprehensive APCS at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf, has a direct impact on the codes in dispute of 27687 and 27691 as described below.

10.2.3 - Comprehensive APCs

Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

HCPCS codes assigned to comprehensive APCs are designated with status indicator J1, See Addendum B at www.cms.hhs.gov/HospitalOutpatientPPS/ for the list of HCPCS codes designated with status indicator J1.

Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:

- ***major OPPS procedure codes (status indicators P, S, T, V)***
- *lower ranked comprehensive procedure codes (status indicator J1)*
- *non-pass-through drugs and biologicals (status indicator K)*
- *blood products (status indicator R)*
- *DME (status indicator Y)*
- *therapy services (HCPCS codes with status indicator A reported on therapy revenue centers)*

The status indicator shown at Addendum B for the services in dispute are as follows:

- Procedure code 28300 has status indicator J1, denoting packaged services paid at a comprehensive APC rate.

- Procedure code 27687 has status indicator T. For this claim reimbursement for this service is included with payment for the primary procedure.

- Procedure code 27691 has status indicator T. For this claim reimbursement for this service is included with payment for the primary procedure.

2. The total recommended reimbursement for the disputed services is $9,394.68. The insurance carrier has paid $9,394.68 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 25, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.